CHAPTER 13
SECTION 3.1

ANESTHESIA

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I. ISSUE

How is reimbursement for anesthesia services to be determined?

II. POLICY

A. Anesthesia Services Reimbursed Based on CPT Surgery Codes.

1. The American Society of Anesthesiologists and many state medical societies have developed relative value guides from which an anesthesiologist may determine the fee for a given service. These guides generally assign base unit values to the different surgical procedures and services listed and provide for additional units taking into account such factors as time, risk, age of the patient, etc. The contractor shall establish a prevailing charge conversion factor using the individual anesthesiologists conversion factors in the same manner that prevailing charges are developed from actual charges. For example, where an anesthesiologist has billed $153 for an anesthesia service and the total of the relative value units for the service rendered (base, time, and other modifier) was 9, the physician has in effect used a $17 conversion factor. The prevailing charge conversion factor shall be computed by arraying the individual conversion factors in ascending order and weighting each by the frequency of services on which it was based. An actual amount in the array which is high enough to include 80 percent of the cumulative conversion factors shall be the prevailing charge conversion factor.

2. Units used by contractors (for base, time, and complicating factors) should be clearly established and conform as closely as possible to those used in billing for anesthesia services in the contractor's area. The base units should be part of the contractor's relative value system and should be established for each procedure for which anesthesia can be used.

Time units should be consistent for all procedures. Whatever time units are used, any fraction of a unit should be considered a whole unit in determining reimbursement. The contractor shall also have clearly established units for complications such as high-risk patients, age, etc. Thus, reimbursement for a procedure with no complications and which took 65 minutes (where the contractor uses time units of 15 minutes) and which has a base value of 3 would be determined using a total of 8 units.

3. Anesthesia claims are to be based on the surgical procedure code combined with an anesthesia type of service.

4. Where the majority of anesthesiologists bill dollar amounts for services without any indication of the relative value units associated with their services, the contractor must establish prevailing charge screens for such services in the same manner as for other physicians. Under this approach, any amounts for time, risk, age, etc., which are charged by a physician using a relative value scale and a dollar conversion factor to set the fee will not ordinarily be a basis for allowing amounts above the applicable prevailing charge. However, higher amounts can be allowed when they are justified by unusual circumstances or medical complications (see Chapter 13, Section 4.1).

B. Anesthesia Services Reimbursed Based on CPT Anesthesia Codes.

1. Procedure codes. Claims are to be billed using the CPT-4 anesthesia codes (range 00100 - 01999).

2. Payment. Payment is calculated by multiplying the applicable conversion factor by the appropriate number of base units plus time units for each code.

a. There are two conversion factors--one for physicians and one for non-physicians, and the conversion factors are adjusted by wage indexes for each locality. The locality-specific conversion factors are adjusted in the same manner applied to CMACs. That is, the current contractor-maintained conversion factors are compared to the Medicare locality-specific conversion factors, and the conversion factors are reduced a maximum of fifteen percent a year or to the Medicare level.

b. Base units for each procedure are derived from the Medicare Anesthesia Relative Value Guide. Time units are 15 minutes, and any fraction of a unit is considered a whole unit. Time units will be as submitted on the claim.

3. Files provided to Contractors. Each year the contractors will receive a file which contains the conversion factors (two per locality) along with the number of base units per CPT-4 code.

4. Identification of provider. Since payment rates distinguish between physicians and non-physicians, each anesthesia claim must identify who provided the anesthesia. In those cases where part of the anesthesia service is provided by an anesthesiologist and the remainder by a nurse anesthetist, the claims(s) must identify exactly the services provided by each type of provider, so that the appropriate payment level can be used.

C. If the care is otherwise eligible for benefits, anesthesia services rendered by a nurse anesthetist in private practice are payable under the following conditions:

1. There is physician referral and the anesthesia service is performed under the supervision of a physician or dentist.

2. The nurse anesthetist is operating within the scope of a valid license or certification in the jurisdiction where the anesthesia is rendered.

3. The nurse is a Licensed Registered Nurse.

D. Anesthesia Care Teams. An anesthesia care team occurs whenever two or more providers render the anesthesia services for a single surgical session. Most often the two providers will be an anesthesiologist and a nurse anesthetist. When anesthesia services are provided by an anesthesia care team, reimbursement cannot exceed what would have been paid had the services been provided by a single provider.

1. Reimbursement may be made only for actual services provided. For example, if a nurse anesthetist provides the complete anesthesia services for a surgical session, only the nurse anesthetist can be reimbursed for the anesthesia services. If an anesthesiologist "supervises" the nurse anesthetist but provides no direct care to the patient (e.g., does not examine the patient, is not in the operating room at any time during the surgery, etc.), no payment can be made to the anesthesiologist. If the anesthesiologist believes the supervision warrants reimbursement, that is an issue to be resolved between the anesthesiologist and the nurse anesthetist. TRICARE will neither split the payment nor reimburse any amount for supervision over and above the normal allowable amount paid to the nurse anesthetist for the anesthesia service.

2. When a nurse anesthetist employed by an anesthesiologist provides services under the anesthesiologist's direct, personal, and continuous supervision, the anesthesiologist must include the charges for the employee's services in the bill for his services. The payment for the range of services provided by both the anesthesiologist and the anesthetist employee will be made to the anesthesiologist, or the patient in the case of nonparticipating claims, on an allowable charge basis.

3. When an anesthesiologist does not provide the complete range of anesthesia services (e.g., the operating room service was not personally performed by the anesthesiologist or the anesthesiologist was assisted by a nurse anesthetist who is not their employee), the allowable charge for the physician's service should be less than the amount that could have been allowed had he personally performed the full range of services (e.g., it should not be equivalent to the relative value assigned to the full procedure).

a. In such cases the anesthesiologist must identify on their bill (or claim forms) the direct personal services they themselves render to the patient, so that an appropriate judgment can be made as to what portion of the allowable charge for the total service can be allowed and reimbursed to the anesthesiologist in the particular case.

b. Similarly, if a nurse anesthetist in private practice provided some of the anesthesia services, their claim also must identify the services they rendered so that an appropriate judgement can be made as to what portion of the allowable charge for the total service can be reimbursed to them.

c. In some instances, the contractor may have to consult with its medical staff before reaching the appropriate allocation of the allowable charges.

4. When the only service performed by an anesthesiologist is a personal examination of the patient in order to determine the appropriate agent to be used by a nurse anesthetist, payment may be made for a consultation.

5. The services of a nurse anesthetist employed by a hospital and the services of interns and residents are covered as hospital services. Also costs attributable to any compensation paid to an anesthesiologist for institutional services, such as teaching, supervision, and administration are similarly covered and are reimbursable to the hospital on the basis of other institutional charges. Payment can be made on an allowable charge basis only for direct patient care services personally rendered by the anesthesiologist or by a nurse anesthetist in private practice.

6. The amount allowed for a physician's services in the teaching setting must be appropriately reduced whenever the physician does not furnish in-person supervision of an intern or resident for the entire period during which anesthesia was administered. For example, an amount based on time units can be included in the allowable charge only for time the physician was present and furnishing either (a) direct personal services to the patient, or (b) in-person supervision of an intern or resident during the procedure. In this regard, however, there may be individual cases, considering such factors as the nature of the patient's condition, the experience of the residents, the proximity of the operating rooms, and the time spent in each operating room by the anesthesiologist, in which the contractor's medical staff may determine that the anesthesiologist was present for sufficient time in each of two cases to warrant payment on an allowable charge basis for the full-time units in both cases. Claims files in such situations must be adequately documented and payment depends on an individually written determination by the contractor's medical staff.

E. Nothing in the foregoing precludes a physician who provides anesthesia services from establishing an "attending physician" relationship with a patient in a teaching hospital where the following criteria are met. In such cases, payment will be made on an allowable charge basis to the extent that the services are covered if the physician:

1. Personally examines the patient;

2. Is present at induction and emergence; and

3. Performs other activities (with respect to the distinct segment of the patient's treatment) which distinguish an attending physician relationship.

F. These procedures are to be followed for all anesthesia claims including epidural anesthesia.

G. Anesthesiologist bills for the insertion of a Swan-Ganz catheter, CVP line or arterial line. Claims submitted by anesthesiologists for Swan-Ganz catheterization, or the insertion of CVP or arterial lines are to be reimbursed at 50% of the prevailing allowance for these services when performed in conjunction with the administration of anesthesia. If the above procedures are performed separately by the anesthesiologist, that is, not in conjunction with the administration of anesthesia, reimbursement is to be made at the full allowance.

H. Anesthesia administered by operating surgeon.

1. In an office or similar setting. Anesthesia by local infiltration or metacarpal/digital block or topical anesthesia administered by the operating surgeon in connection with surgery performed in the surgeon's office or similar setting is covered as part of the surgery. No additional payment may be made for the anesthesia, though, since the surgical prevailing

charge includes the anesthesia. If the physician itemized a separate charge for the anesthesia, it is to be combined with the surgical charge in determining the allowable reimbursement.

2. In a hospital surgery suite or similar setting. No payment is to be made for anesthesia administered by the attending physician (surgeon or obstetrician) or dentist, or by the surgical, obstetrical, or dental assistant (see Chapter 2, Section 1.2).

I. The management of pain relief during labor and delivery (e.g., labor intrathecal analgesia / anesthesia (LIA) or intrathecal narcotic administration, etc.) administered by an authorized provider shall be reimbursed as outlined in Chapter 13, Section 3.8, paragraph II.E.4., under "Exceptions".

J. Anesthesia related to multiple surgical procedures.

1. General. When multiple surgical procedures are performed, the base units are to be reimbursed only for the major procedure. The major procedure is the one with the greatest basic unit value. Of course, the time units will reflect the entire surgical session.

2. Multiple surgical procedures including noncovered procedures. Administration of anesthesia for noncovered services is not covered. When multiple surgical procedures are performed, some of which are not covered (e.g., a tubal ligation and an abortion), only the anesthesia for the covered services is to be reimbursed. The allowable amount for the covered services is to be determined by allowing the base units for the major covered procedure and by prorating the time units (if the claim does not identify the time units associated with each procedure). The proration will be based on the basic unit value for the code which includes the surgical procedure. For example, assume none time units were charged, and the basic unit value of the covered procedure is four units and the basic unit value of the noncovered procedure is two units. The contractor is to allow four base units plus two-thirds of the time units (six time units) for a total of ten units.

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